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Message from the President

Anne Heyen, DNP, RN, CNE

Hello and welcome, my name is Anne Heyen and it is my honor and privilege to serve you as President of the Missouri State Board of Nursing. I was originally appointed to the board in 2015 and spent the last year as the Vice President. The tremendous amount I learned while serving on the board is thanks to the fellow board members and past presidents who are still serving on the board, along with the exceptional Executive Director and other board staff. The majority of my professional career has been spent in nursing education. I taught in an associate degree program and more recently a baccalaureate degree program. The mission of the Board is to provide public protection through the regulation of nursing education, licensure and practice. I look forward to the opportunity to serve in support of this mission.

In addition to myself being elected President of the Board, Mariea Snell, DNP, MSN, RN, FNP-BC was elected Vice President and Bonny Kehm, PhD, RN, was elected Secretary of the Board.

Dr. Snell is the coordinator of the Doctor of Nursing Practice program for Maryville University. In addition to her faculty and administrative role, she practices as a Family Nurse Practitioner for Peoples Health Centers in St. Louis. She holds a doctorate in nursing from St. Louis University, a master's of science in nursing from Indiana State with a concentration in family practice and a bachelor's in nursing from Barnes Jewish College of Nursing at Washington University Medical Center. Dr. Snell has extensive experience in research, education and community health. She has a passion for working with the underserved and embarked on her nursing career to reach groups that need care the most. She has been on the board since February 2013.

Dr. Kehm is the Faculty Program Director in the baccalaureate and Master of Science programs for the School of Nursing at Excelsior College, where she designs curriculum and research. Dr. Kehm earned her bachelor's and master's degrees in nursing from Webster University, her doctorate in nursing education from Capella University, and her graduate certificate in Health Care Informatics from Excelsior College. Dr. Kehm has worked to improve nursing curriculum, expand opportunities for graduate nurses to transition from the clinical setting to academia and instill leadership skills in the science and art of nursing. Dr. Kehm's commitment to improving the nursing profession includes work to increase awareness of interprofessional education opportunities that link nursing, nutrition, and health sciences education to improve interdisciplinary learning. Her research has been supported by The Robert E. Kinsinger Institute for Nursing Excellence and Sigma Theta Tau Kappa At-Large grant. She has also been honored as a speaker at the Royal College of Nursing Centennial International Conference in England. She has served on the NLN Foundation Scholarships Selection Committee, Elsevier Education Advisory Board, and as an NLN Ambassador. Dr. Kehm was recipient of the Missouri Organization of Nursing Leaders 2016 Rising Nurse Leader Award. She has been on the board since October 2017.

Executive Director Report

Lori Scheidt, MBA-HCM

Licensed Practical Nurses Licenses Set to Renew in March 2018 – Act Now!

Licensed Practical Nurse (LPN) renewal postcards with PIN numbers will be mailed in early March 2018. The postcard is mailed to the address we have on our records, so it is very important that you inform our office in writing whenever you change addresses. A change form can be found on the board's website and also in this publication. You have a legal responsibility to change your name and/or address within 30 days of the change. Failure to inform the board of your current residence is cause for license discipline.

Before you renew, you need to go to www.nursys.com and enroll yourself as a Nurse in e-Notify. If you enroll now, you will decrease the amount of time it will take you to renew your license. When you submit a license renewal, your license is not automatically renewed. It takes 3-5 business days for your license renewal to be processed. If you are enrolled in Nursys e-Notify as a nurse, you will receive a notification when your license is renewed.

Protect Your License

Protecting your license from potential fraud or identity theft should be a priority for you, especially now as Missouri enters the enhanced Nurse Licensure Compact (eNLC). One of the best ways to safeguard your license is to enroll in National Council of State Boards of Nursing's (NCSBN's) **Nursys e-Notify®**.

Powered by the U.S. boards of nursing, Nursys e-Notify is the only national database for licensure verification of registered nurses (RNs), licensed practical/vocational nurses (LPN/VNs) and advanced practice registered nurses (APRNs).

Quick, easy, secure and FREE, your enrollment takes just a few minutes and you can then receive licensure status updates including multistate and single-state changes within the eNLC. You can track licensure verifications for endorsement and manage multiple licensure verifications. Keeping on top of your license status can help you prevent fraudulent licenses or certificates being issued in your name.

Nursys is designated as a primary source equivalent database through a written agreement with participating boards of nursing (BONs)*. Nursys is live and dynamic, and all updates to the system are pushed directly from participating BON databases through frequent, secured data updates.

Learn more about Nursys e-Notify by viewing an introductory video at www.nursys.com/enotify-video or by visiting www.nursys.com. For questions, contact nursysenotify@ncsbn.org.

Enroll at www.nursys.com/e-notify and select "As a Nurse" to complete the registration process.

** See www.nursys.com for participating BONs.*

The Enhanced Nurse Licensure Compact (eNLC)

Unlocking Access to Nursing Care Across the Nation

A new era of nursing licensure was ushered in on July 20, 2017, when the 26th state necessary for eNLC enactment

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Important Telephone Numbers

Department of Health & Senior Services (nurse aide verifications and general questions)	573-526-5686
Missouri State Association for Licensed Practical Nurses (*MoSALPN*)	573-636-5659
Missouri Nurses Association (*MONA*)	573-636-4623
Missouri League for Nursing (*MLN*)	573-635-5355
Missouri Hospital Association (*MHA*)	573-893-3700

Number of Nurses Currently Licensed in the State of Missouri

As of January 2, 2018

Profession	Number
Licensed Practical Nurse	25,029
Registered Professional Nurse	106,677
Total	**131,706**

SCHEDULE OF BOARD MEETING DATES THROUGH 2018

February 28–March 2, 2018

May 23–25, 2018

August 8–10, 2018

November 7–9, 2018

Meeting locations may vary. For current information please view notices on our website at http://pr.mo.gov or call the board office.

If you are planning on attending any of the meetings listed above, notification of special needs should be forwarded to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 or by calling 573-751-0681 to ensure available accommodations. The text telephone for the hearing impaired is 800-735-2966.

Note: Committee Meeting Notices are posted on our web site at http://pr.mo.gov

Return to "Nursing 101"

When a nurse is terminated and the employer feels the Nurse Practice Act was violated the Board receives a complaint report. The Complaint is then investigated by the Board of Nursing's investigative staff. As Director of Compliance for the Board of Nursing, I read some of the investigative reports that result from these complaints. I have recently read practice complaints that resulted when a nurse did not follow a basic nursing skill that would have been taught early on in nursing studies and reinforced throughout the entire curriculum what I refer to as "Nursing 101."

This past month I read a couple of complaints that resulted in a licensee being terminated from their first nursing job. In these situations the licensee had only been licensed as a nurse for approximately six months. I have read complaints in the past of a nurse being terminated from their first job but those have in general been related to a new nurse not fitting in with the culture or choosing a job that she is unable to keep up with because she lacks experience. These complaints concerned me because in both of these complaints the licensee didn't follow what they learned in "Nursing 101."

In one instance it was difficult to determine what care the nurse provided because she did not document an assessment and did not document any of the interventions that she performed. In this situation a video did provide proof that she entered the room hourly, however it is unknown what she did in the room because she did not document if she was obtaining labs, assessing the patient or simply walking in and out of the room. Unfortunately this patient had a change in condition that the nurse did not detect and the facility felt due to the lack of documentation the nurse neglected the patient. Documentation is taught in "Nursing 101." It is an essential part of what a nurse does and "if it is not documented then it is not done!"

In another instance a new licensee seemed to be disassociated from the patients. The licensee was checking her cell phone for texts and voice messages, on the computer on non-work related websites, not answering call lights, and taking over an hour to give a patient a pain medication. Family described the licensee as unprofessional and like she did not care about the patient. In a nursing clinical situation these are all behaviors that faculty would not allow. The behaviors this new graduate demonstrated gave the facility the impression that she did not want to be a nurse to the patients and they terminated her for patient neglect. Demonstrating professional behaviors at all times is taught in "Nursing 101" and is an essential part of what a nurse does.

Like the new licensee in the paragraph above, the more experienced nurse I read about in another investigation was terminated for not providing essential nursing care. It was reported that she was off the floor for long periods of time, giving medications late, not completing assessments and orders, and not doing patient education. The "discharge begins at admission" statement that was taught in "Nursing 101" did not occur and delayed a patient discharge. The behaviors that the facility mentioned and terminated the licensee for are behaviors that clinical faculty would not allow in the education setting.

Nursing skills are taught along with professional behavior in "Nursing 101." Many skills are taught and performed in skills labs and then brought to the clinical setting. As nurses gain experience they also gain new skills but they must also be able to correctly perform the skills taught in their basic nursing fundamental classes. In an investigative report recently a more experienced nurse gave a sub-q injection in an incorrect spot causing a hematoma, and did not label IV tubing. Further, she inserted a catheter to address urinary retention, did not get urine return, but did inflate the balloon causing trauma to the urethra. The skills that were done incorrectly were all "skills lab" skills. It is important to maintain or review the "old" skills to maintain competency as we progress in our careers.

Each nursing job is full of what we learned in school, what I call "Nursing 101." When we are new to the career we need to apply those basics and as we progress in our careers we need to review those basics. Every employer expects a nurse to demonstrate those "Nursing 101" skills of professionalism, documentation, communication, and basic nursing skills throughout their career.

Executive Director Report

Executive Director continued from page 1

signed legislation into law. The Interstate Commission of Nurse Licensure Compact Administrators, the governing body of the eNLC, set the date of Jan. 19, 2018, for eNLC implementation.

So what does this mean for you?

The eNLC, which is an updated version of the original NLC, allows for registered nurses (RNs) and licensed practical/vocational nurses (LPN/VNs) to have one multistate license, with the ability to practice in person or via telehealth in both their home state and other eNLC states. All applicants for a multistate license are required to meet the same licensing requirements, which include federal and state criminal background checks, which may be biometric.

On Jan. 19, 2018, nurses with active eNLC multistate licenses may begin practicing in the 26 eNLC states. In original NLC states that have enacted eNLC legislation like Missouri, a nurse who holds a multistate license on or before July 20, 2017, will be grandfathered into the eNLC and will be able to practice in other eNLC states beginning on the implementation date. You do not need to take any action unless you move to another state. If you do move to another state that is a member of the eNLC, you will need to meet the Uniform Licensure Requirements (ULRs) in order to obtain a multistate license. Likewise, all nurses applying for licensure and declaring Missouri their home state will need to meet the ULRs.

A nurse residing in a state that is new to the eNLC will be able to practice in other eNLC states contingent upon the board of nursing issuing the nurse a multistate license.

The current states in the eNLC include: Arizona, Arkansas, Delaware, Florida, Georgia, Idaho, Iowa, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Nebraska, New Hampshire, North Carolina, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, West Virginia and Wyoming. Work will continue toward the ultimate goal of having all 50 states in the compact.

You have to keep in mind that your nursing practice takes place where the patient is located. If the patient is located in another state, you need to be licensed to practice in that state. A multistate license helps to facilitate that, but you must still adhere to the laws and regulations of the state in which you are practicing, whether that be in person or via telehealth. The practice of nursing is not limited to patient care and does include all nursing practice, as defined by state practice laws of the state in which the patient/client is located.

If you need to practice in a state that is not a member of the eNLC, you will need a single-state license, issued from that state regardless of whether you hold a multistate license.

Additional information about the eNLC can be found at https://www.ncsbn.org/enhanced-nlc-implementation.htm or www.nursecompact.com. For the latest information, follow the eNLC on Twitter or Facebook.

The Many Lanes of APRN Roles and Populations

Kathy Hoebelheinrich, MSN, APRN-NP, ANP-BC, BC-ADM, CDE
Nursing Practice Consultant, NBON

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The National Council of State Boards of Nursing (NCSBN) hosts an annual Roundtable for Advanced Practice Registered Nurse (APRN) stakeholders to discuss common issues and concerns regarding APRNs. Invitees to the 2017 meeting included nursing regulators, educators, professional societies, credentialing agencies and others interested in the grassroots work of moving toward unified elements of the 2008 Consensus Model for APRN Regulation (Figure 1).

The theme of 2017 Roundtable, *The Many Lanes of APRN Roles and Populations*, aptly embodied the current tempo of inquiries to nursing regulators regarding the alignment of APRN education and certification when the focus of practice shifts beyond role and population focus.

Advanced practice nurses commit to a specific APRN role and patient population early in the course of education and training. Board certification is the *driving lane* for practice. Successful completion of a certification examination provides a psychometric assessment of baseline competency for entry into practice for a particular role and population. Nebraska is among those states that require board certification for licensure in order to practice as an APRN. Licensure is *permission to drive* within a defined statutory scope of practice.

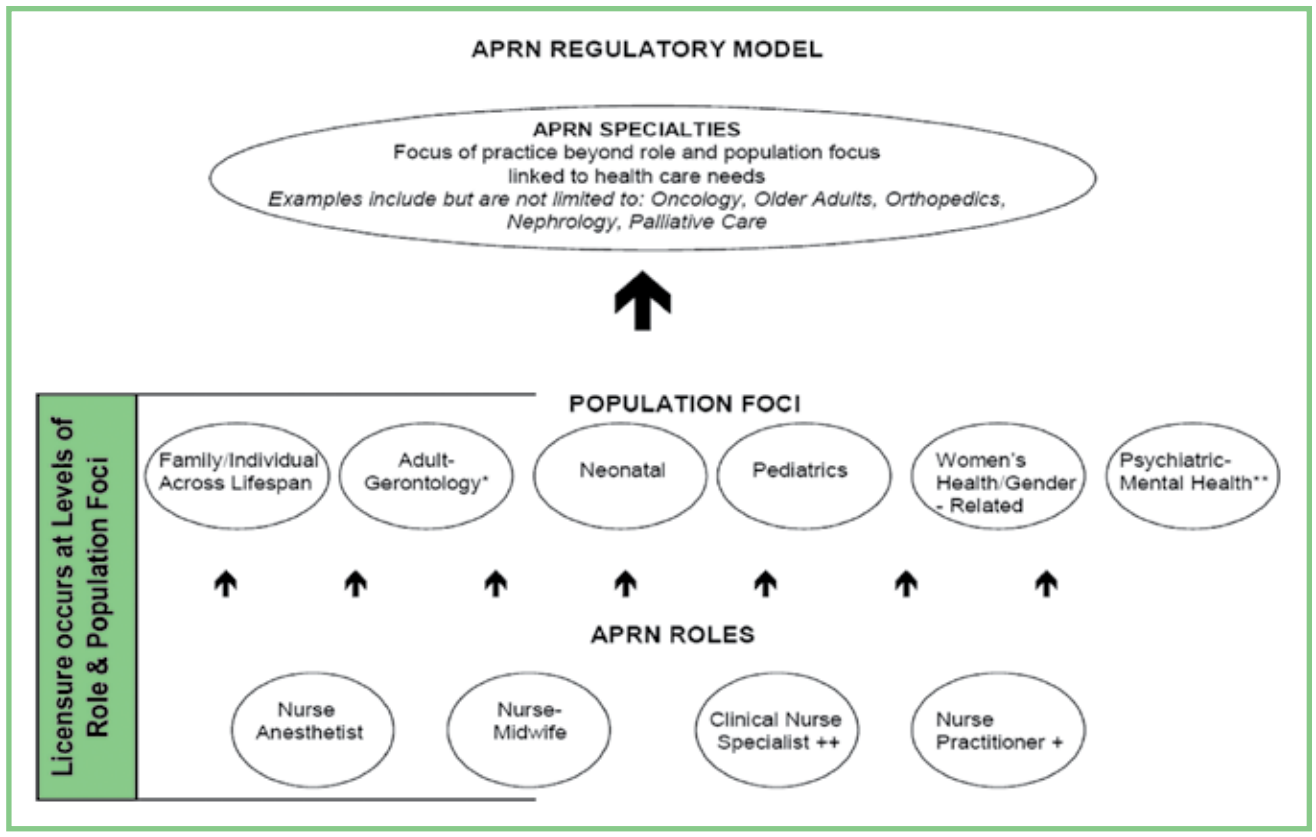
Advanced Practice Registered Nurse specialty education and practice build upon and are in addition to the education and practice of the APRN role and population focus, e.g, a Certified Registered Nurse Anesthetist (CRNA) could specialize in pain management; a Certified Nurse-Midwife (CNM) could specialize in the care of postmenopausal women, a Clinical Nurse Specialist (CNS) could specialize in palliative care, or, the Nurse Practitioner (NP) could specialize in Hematology-Oncology.

Lane drift can occur when the APRN becomes distracted by patient or other circumstances in the practice environment. Lane changes are more significant changes in practice populations and/or required skill sets—and not surprisingly, lane changes come with greater risks if not carefully executed. The lines demarcating lane drift and lane change are not always obvious.

Lane Drift or Lane Change?

Consider the following hypothetical practice situations:

– An experienced Pediatric Nurse Practitioner (PNP) in a Pediatric Hematology-Oncology clinic agrees to provide care to a 23 year-established patient in the practice. The patient anticipates establishing with an adult provider following college graduation and relocation for employment in another city within the next 12 months.
– The PNP is offered a case management position which includes additional responsibilities for hospital rounds for the Hematology-Oncology practice to assist established clinic patients and their families in the discharge transition to home and clinic-based care.
– The PNP is informed that clinic NPs will now be required to rotate evening and week-end call for the Hematology-Oncology practice. Call will include new hospital patient referrals.



Misalignment

Misalignment of APRN practice and credentials can manifest on several fronts:

1. Payer requirements for APRN credentials for reimbursement of services, e.g., behavioral health or primary care
2. A plaintiff attorney requests a clinician/practice/facility to provide evidence for the qualifications of a APRN provider
3. Employers and/or medical credentialing staff do not understand APRN credentials
4. Providers make referrals for specialty practice consultations expecting a physician
5. Patients may not be fully informed regarding the qualifications of APRN providers
6. APRNs fail to recognize employment opportunities that are not safe practice

(Buppert, 2017).

Historically, grandfathering has been the primary mechanism to exempt providers from a new law or regulation based on pre-existing requirements in order to practice. Grandfathering provisions typically assign competency on the basis of the individual having acquired national advanced certification and current practice in the role and population requested (Alexander, 2014). Additionally, in the case of NPs, the abundance of graduates prepared as adult and family practice clinicians has translated to a pipeline, one-size-fits-all supply for employers. Assumptions are made that skill sets can be shaped by the practice setting with experience or on-the-job training, or perhaps, 'jump started' if the individual has had prior experience as a RN.

Defensible Practice

According to Buppert, (2017) notwithstanding that patient safety and outcomes are always front and center, APRNs accepting employment misaligned with education and certification must also take deliberate action to make practice defensible. *Turn signal on… adjust speed, check mirrors and identify the blind spots!* Defensible practice is essentially defined and measurable competencies:

Competency in specialty areas is acquired through additional education, training and experience.

Competency can be assessed in a variety of ways through professional credentialing mechanisms, e.g., examination, portfolio or peer review.

Additional certification in a new specialty area of practice is strongly recommended.

When certification in a particular specialty is not available to APRNs, it may be necessary to identify other alternatives e.g., an immersion course or number of observed procedures. Similarly, be alert to potential pitfalls when training for new devices, products or procedures is accessed through vendors with limited or no means to validate competency.

First-time and new APRN employees should ascertain that orientation, onboarding and training protocols meet personal needs to establish safe and effective practice. Preceptorships and fellowships may be appropriate.

Practice should be consistent, retrievable and reproducible whenever possible, including informed adherence to professional guidelines and standards of care. Development and compliance with employer or practice policies and procedures is also important.

The health care needs of the patient, not the practice setting dictate the qualifications and competencies of the APRN. The APRN should have the knowledge to differentially diagnose and manage the conditions likely to be encountered.

It may be necessary to secure formal relationships and identify mechanisms for the accessibility and on-site availability of other providers.

In summary, APRNs commit early in the course of education and training to a particular role and population focus. Practice lanes are affirmed with professional certification and subsequent licensure. Lane changes are best preceded with planning for the acquisition of new competencies and other means for defensible practice. Advanced practice nurses must necessarily assume responsibility for recognizing practice opportunities that may be misaligned with education and certification, and ultimately present risks to patient safety and outcomes.

References:

Alexander, M. (2014) Guidelines for grandfathering by endorsement. Retrieved from: https://www.ncsbn.org/864.htm

Buppert, C. (2017). The misaligned APRN: Grandfathered or something else? Retrieved from https://www.ncsbn.org/10579.htm

Consensus Model for APRN Regulation: Licensure, Accreditation, Certification and Education. (2008). APRN Consensus Work Group & National Council of State Boards of Nursing APRN Advisory Committee. Retrieved from https://www.ncsbn.org/Consensus_Model_for_APRN_Regulation_July_2008.pdf

WHAT COULD HAPPEN: The Consequences of "Practice Drift" ...Is It Worth the Risk?

Kathy Chastain, MN, RN, FRE and Linda Burhans, PhD, RN, FRE

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PURPOSE & OBJECTIVES

Purpose: To assist nurses in understanding and identifying practice drift and how to eliminate/mitigate effects.

Objectives:

1. Explain "practice drift."
2. Recognize factors that contribute to the occurrence of "practice drift."
3. Discuss the impact of "practice drift."
4. Create a plan to eliminate and decrease "practice drift."

Have you ever…

1) *Deviated from the procedure for safe medication administration?*
   - administered a medication prior to obtaining an order from a provider because you "knew" what the physician would order;
   - borrowed a medication from another patient or used STAT orders to override the system as a workaround to bypass slow pharmacy services;
   - administered a pain medication without completing a pain assessment because you were in a hurry;
   - prepared medications simultaneously for more than one patient because you were pressed for time and/or you were trying to save a few steps;
   - carried medications in your pocket and wasted them at the end of the shift because there wasn't anyone available at the time to serve as a witness;
   - signed as a witness to a narcotic medication waste you did not observe because you trusted your co-worker;
   - left a patient's medications on the bedside table because he/she was on the phone;
   - failed to check 2 identifiers when administering medication because you were in a rush;
   - failed to scan the bar code on a medication because the scanner wasn't working;
   - made assumptions when orders were incomplete or were illegible because you didn't want to bother the provider; or,
   - hidden away unused medications from discharged patients for administration to other patients if needed in the future to avoid delays.
2) *Neglected a patient?*
   - failed to perform an assessment or treatment because the patient was sleeping;
   - silenced a piece of equipment (bed alarm, IV pump, cardiac monitor, etc.) because it kept alarming for no apparent reason and you felt it was disturbing the patients; or,
   - failed to complete the "time out" in surgery because the surgeon was upset with how long it took to set up for his/her patient.
3) *Failed to maintain an accurate patient medical record?*
   - pre-documented an assessment or care delivered to save time because the information was always the same;
   - pre-documented medication administration because you knew you would not have time later; or,
   - waited until the end of the shift to document all assessments and care rendered because you didn't have time during the shift to get it done.
4) *Breached a patient's confidentiality?*
   - out of curiosity, looked up information on a patient you were not assigned to provide care;
   - posted pictures or comments about patients or family members on social media;
   - discussed patient information in a public setting (e.g., elevator or cafeteria) or commented on a patient's condition to another patient or family member.
5) *Exceeded scope of nursing practice?*
   - acted outside your scope of practice by writing "verbal orders" without actually speaking with the provider, believing they would be signed off at next rounds; or,
   - performed a procedure that was outside your scope of practice (e.g., rupturing membranes to induce labor) because the provider instructed you to do so.
6) *Inappropriately delegated a task to an unlicensed staff member?*
   - directed a nurse aide (not appropriately educated and validated competent) to administer a medication or perform a simple dressing change because you were busy with another patient; or,
   - allowed unlicensed personnel to make assignments and delegate patient care tasks to others.
7) *Accepted an assignment when you knew you were not fit for duty?*
   - worked while so fatigued that you were nodding off to sleep because you agreed to work an extra shift at the request of your manager; or,
   - worked an early shift while still "hung over" from a party that ended only a few hours before.

Chances are you have done some of these yourself, or if not, you have worked with someone who has! The multiple "at-risk" behaviors listed above all describe "practice drift." The term "practice drift" is another way of describing a "work-around," "shortcut," or "rule-bending" done in order to accomplish an immediate goal, to meet a perceived expectation of another, and/or to promote efficiency (Collins, 2003). All of these incidents are types of practice violations which the NC Board of Nursing has investigated. Thankfully the vast majority of these incidents did not result in serious negative patient outcomes but each incident represents a "drift" from the standard of care and has the potential to jeopardize patient safety.

STOP READING: Make a list of work-arounds, shortcuts, and rule-bending in your practice setting. What variations from standards of practice or policies and procedures have you witnessed? Which variations have you used? How often does "practice drift" occur in your practice and that of your co-workers?

Behavioral research has shown that all humans are mentally programed to drift into unsafe habits, to lose perception of the risk attached to everyday behaviors, or to mistakenly believe the risks taken to be justified. Decisions about what is important on a daily list of tasks are based on the immediate desired outcomes and over time, as perceptions of risk fade away, individuals try to do more with less and take shortcuts, drifting away from behaviors they know are safer (ISMP, June 2012).

Articles published by the Just Culture Community, have identified "at-risk" behaviors as the most common of the 3 types of errors (human, at-risk, reckless). Marx of Outcome Engineering (2005) explains,

> "We all tend to lose perception of the risk attached to everyday activities, or mistakenly believe in some situations a risk is justified. Often our decisions to circumvent an evident or perceived workflow hindrance are based on immediate outcomes (time saver) in order to meet a goal or to achieve it more readily and do not consider the potential or uncertain consequence (patient harm) which is more *remote*."

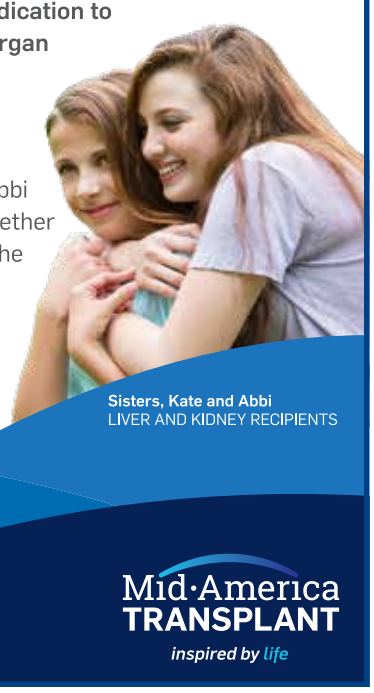
Studies have shown that once you have bent the rules and had a favorable outcome and/or a positive response from your peers and supervisors, you are likely to be tempted to do it again (Collins, 2003). If left unquestioned, the rule-bending action then tacitly becomes acceptable practice not only by that individual but may be adopted by others in the unit or facility and many times leads to what is referred to as a "cultural norm." However, work-arounds and rule-bending are often just temporary fixes for bigger problems in the system and do not promote an environment supportive of safe patient outcomes.

STOP READING: Go back to your "practice drift" list. For each variation, list the reason(s) for those variations. Why do you and your co-workers use these work-arounds and shortcuts and bend established rules? What are you trying to achieve? What problems in the system or environment make it seem necessary to use these approaches?

Consider the following scenario:

Megan, a newly-employed Registered Nurse in the Operating Room of a small rural hospital, was assigned to circulate with another

WHAT COULD HAPPEN continued on page 6



WHAT COULD HAPPEN continued from page 5

experienced nurse on a surgical case for Dr. S, a very impatient surgeon. The set up for the procedure was taking longer than expected because a specific piece of equipment that had been requested the day before could not be located. Dr. S voiced his frustration and threatened that he would cancel the surgery and "start taking his surgeries elsewhere" as they were never ready and always caused him to be behind in his schedule. The nurses rushed to finish the set up and due to the delays the experienced nurse instructed Megan that they would forgo doing the required "time out" to verify the patient, procedure, site, allergies, and antibiotics administered. Megan voiced concerns but was assured this was "common practice" for this surgeon to keep him happy as you never wanted to be on his bad side.

This example demonstrates how "practice drift" became a "cultural norm" for this facility. Based on extensive studies and the patient safety literature, the risk severity potential of omitting the "time out" procedure was *high*, but the probability of incident was incorrectly perceived by the nurses to be *low* as there had been no reports of wrong patient or wrong site surgeries in this hospital. The decision drivers to "work-around" the rule included the intimidation the nurses felt due to the surgeon's threats, the nurses' desire to make up for lost time, and the time delay caused by the lack of preparedness in failing to verify the day before that the equipment was available. As described in this example, it is likely that this cultural norm will be perpetuated by the new nurse for whom this was identified as acceptable behavior. In addition, this cultural norm was reinforced again for all the nurses by the lack of untoward outcomes in this case.

STOP READING: Go back to your "practice drift" list. Highlight those variations that have become "cultural norms" in your setting. Is this "practice drift" so common that it is used routinely by all nurses? Is it used only by some of the nurses? If so, why do the other nurses not use these approaches?

Dr. Van Sell (2012), noted that nurses will engage in a reasoned, intentional rule bending behavior to solve an immediate problem and not realize the potential negative consequences. Factors such as staffing levels, patient acuity, workload, time constraints, interruptions/emergencies, lack of access to providers, lack of input in design of workflow and procedures, familiarity and trusting relationships with providers, and lack of proper working equipment/supplies/medications are just some of the challenges nurses face every day when trying to do what needs to be done to provide effective patient care.

Work-arounds develop in response to factors that:

- are perceived to prevent or undermine nurses' care for their patients;
- are not considered in the best interests of the patient;
- make performance of their job difficult; or
- potentially threaten professional relationships.

Now, can you identify "practice drift" in the following scenario?

Cindy, a Licensed Practical Nurse, has worked on the evening shift in a long term care skilled nursing facility for a number of years. The facility does not have an on-site pharmacy; therefore, all ordered resident medications are obtained from a pharmacy in a neighboring town. On the date of this incident, a new resident was transferred from the hospital to Cindy's unit. They were understaffed, which was not an uncommon occurrence on that unit. That evening Cindy was falling behind with all the tasks she was assigned to complete. She completed the admission assessment but failed to review the orders. The Unit Secretary transcribed all the medication orders onto the Medication Administration Record (MAR) for Cindy to verify. Cindy was preparing to do her first medication pass for the shift. She took the Medication Administration Record (MAR) without verifying the orders because she had no doubts that it was accurate. She proceeded to pre-pour all scheduled medications for all residents for the entire shift and place them into individual baggies which she labeled with the residents' room numbers. At the same time, she documented that all medications poured had been administered at the times noted in the MAR. She believed these practices to be safe. She had worked with these residents for a long time and knew who they were as well as what medications they took. Throughout the shift, she completed the medication passes which she had pre-poured and pre-documented.

The new resident had an order for an oral antibiotic which had not been delivered. Cindy knew another resident on the unit was taking this same medication so she "borrowed" one dose because she didn't have time to wait on the pharmacy. She failed to check the new resident's allergies, thus failing to see that there was a documented allergy to the antibiotic she had administered. The resident had an allergic reaction resulting in the resident having to be transferred back to the hospital.

While trying to take care of the transfer arrangements for the above resident, a nursing assistant (who is currently in nursing school) informed her that another resident was requesting her pain medication. Cindy reviewed the MAR and noticed the medication was ES-Tylenol. She poured the medication and handed it to the nursing assistant directing her to take it to the resident. In addition, a nurse arrived at 8:30pm to assist with medication administration but left and went back to her own unit when she reviewed the MAR and saw all medications had already been administered through 10:00pm doses. The relief nurse reported to the supervisor that there was a discrepancy related to medication administration.

The above scenario involved multiple "practice drifts." How many did you find?

- Insufficient staff on the unit contributed to Cindy's decisions to "cut corners." She did not request assistance because she "knew" it would not be available, leaving the supervisor unaware of the unit status.
- She rationalized that she did not have to check the orders and MAR because she trusted the secretary and believed she would not make an error in transcribing.
- She failed to realize that the unit secretary was not educated in clinical nursing and pharmacology and would not likely identify the problem between the resident's allergies and the medication ordered.
- In her rush to complete the medication pass, she omitted the safety check of reviewing the allergies as well.

- Instead of waiting on the pharmacy or calling to see why the resident's medications had not been delivered, Cindy decided to bypass policy and borrow the medication from another resident. Had she called the pharmacy she would have been informed that there was a question regarding the order. This third safety mechanism would have prevented an error.
- Cindy believed that pre-pouring all the medications at once would save her time and be more efficient. Because she knew the patients, she believed that she could label the baggies with room numbers only. She chose to ignore all patient safety policies and procedures.
- Cindy's decision to pre-document all the medications that were scheduled to be administered on her shift ultimately resulted in confusion as to what medications had been administered when another nurse came to assist. Notification of the supervisor resulted in an internal investigation into Cindy's medication administration practices and resulted in a report to the Board. As a result of this action, Cindy's credibility was called into question causing her employer to question if she falsified patient records routinely.
- Finally, Cindy inappropriately delegated medication administration to an unlicensed nursing assistant. This, too, was a violation reported to the Board.

Ultimately, Cindy's actions on this shift demonstrated extreme "practice drift." Her overall intent was to provide the best care possible with limited resources. However, the time Cindy thought she was saving by using shortcuts, bending rules, and implementing work-arounds, resulted in compromised patient care, damage to her professional reputation and credibility, a potential loss of her job, and a potential sanction of her nursing license.

It is not uncommon for any one of us, when faced with having to do more with less or when pushed for time, to find ways to use work-arounds and take shortcuts. In a busy work environment, particularly one that is understaffed, rule-bending may seem like the only solution. But none of these influence substantive change and they only provide a temporary fix when what is needed is a change in the underlying condition that made work-arounds, short-cuts or rule bending necessary.

"Practice drifts" operate as adaptions to inefficiencies and have the potential to both subvert and augment patient safety. Occasionally, workarounds operate as localized acts of resilience, are at times crucial to the delivery of services, place the patient's best interests at the forefront, operate as adaptions to inefficiencies, and provide opportunities for improvement. When operating in this manner, they are used as unique, short-term solutions and the opportunities for improvement are immediately addressed. More frequently, however, because rule-bending, work-arounds, and shortcuts circumvent safety blocks, mask environmental and operational deficiencies, and undermine standardization they have the potential to jeopardize patient safety as well as your career. When a patient is injured because you deviated from the standard of care, there is little defense to be found (HPSO, 2016).

Rules: we can't live without them, but there is probably not a day goes by when we don't break or bend one. Rule-bending, work-arounds, and shortcuts are all reflective of the "practice drift" used to achieve specific outcomes. They often seem like the only solution to fixing what is wrong. They become part of the culture and the need to identify and address the root cause of the issue is hidden. We fail to see that we have institutionalized a temporary, inadequate fix. In many cases, it is not until an adverse event requires deeper examination that the underlying conditions that led to unsafe "practice drift" are identified.

Nurses, according to the Gallup Poll, have ranked as the most trusted profession for the last 14 years (ANA, 2015). Nurses strive to do a good job and to provide safe, effective care. We strive to identify more efficient ways to accomplish effective outcomes. Unfortunately, once we get comfortable in doing something, our practice may begin to drift in an attempt to find ways to accomplish more with less or to do something "faster" or "better." We lose sight of the risk inherent in the resulting deviations from established standards of care, policies, and procedures. We assume that risk through the behavioral choices we make. When a patient is injured because we deviated from the standard of care, we bear that responsibility.

The NC Nursing Practice Act (Law) and Rules provide clear direction concerning the variables that determine the responsibilities or assignments that can be safely accepted by an RN or LPN. Likewise, specific criteria designate considerations when assigning or delegating to others. Nurse manager and administrator responsibilities for staff, unit environment, and nursing systems are also spelled out.

STOP READING: Explore the NC Nursing Practice Act (http://www.ncbon.com/dcp/i/laws-rules-nursing-practice-act-nursing-practice-act) and Administrative Code Rules (http://www.ncbon.com/dcp/i/laws-rules-administrative-code-rules-administrative-code-rules) to identify sections relevant to this discussion.

All nurses must strive to uncover and address the underlying causes of rule-bending, work-arounds, and shortcuts to affect substantive change. Nurses, nurse managers, and administrators must work together to identify and address the underlying issues in each work environment – both chronic and acute – which influence "practice drift." Nurses must speak out to identify the "practice drift" they and their peers are using; specifically identify the underlying reasons: short staffing, inadequate supplies, unresponsive pharmacy services, inadequate education, etc.; and collaborate with managers and administrators to identify effective, evidence-based solutions. It is essential that safe solutions to underlying problems be implemented. Patient safety and well-being is the ultimate shared goal.

NOW: Go back to your "practice drift" list and make a plan to address at least one variation! How will you alter your own practice to move away from at-risk behavior? How will you communicate the risks of "practice drift" to your co-workers? How will you address the underlying system changes with your manager and administrator?

IN THE FUTURE: Prioritize your "practice drift" list and address one at a time. Enlist support and involvement from your co-workers and manager. Patient safety and well-being is your ultimate shared goal!

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NOTIFICATION OF NAME AND/OR ADDRESS CHANGE

☐ NAME ☐ ADDRESS ☐ PHONE ☐ ALTERNATE PHONE ☐ EMail

☐ RN ☐ APRN ☐ LPN

Missouri License Number _____ Last 4 Digits of Social Security Number _____

NAME AS CURRENTLY IN OUR SYSTEM

Last Name (Printed) _____ First Name (Printed) _____

NEW INFORMATION

Last Name _____ First Name _____ Middle Name _____

(_____)_____ (_____)_____ _____

Daytime Telephone Number Alternate Phone Number E-mail Address

PRIMARY STATE OF RESIDENCE ADDRESS: (where you vote, pay federal taxes, obtain a driver's license)

Physical address required, **PO boxes are not acceptable**

CITY STATE ZIP

MAILING ADDRESS (ONLY REQUIRED IF YOUR MAILING ADDRESS IS DIFFERENT THAN PRIMARY RESIDENCE)

STREET OR PO BOX

CITY STATE ZIP

☐ I declare _____ as my primary state of residence effective _____.
(primary state of residence) (effective date)

☐ I am employed exclusively in the U.S. Military (Active Duty) or with the U.S. Federal Government and am requesting a Missouri single-state license regardless of my primary state of residence.

Information on the Nurse Licensure Compact can be found at www.ncsbn.org/nlc.htm
In accordance with the Nurse Licensure Compact **"Primary State of Residence"** is defined as the state of a person's declared fixed, permanent and principal home for legal purposes; domicile. Documentation of primary state of residence that may be requested (but not limited to) includes:

- Driver's license with a home address
- Voter registration card displaying a home address
- Federal income tax return declaring the primary state of residence
- Military Form no. 2058 – state of legal residence certificate
- W-2 from US Government or any bureau, division or agency thereof indicating the declared state of residence

Proof of any of the above may be requested.

When your primary state of residence is a non-compact state, your license will be designated as a single-state license valid only in Missouri.

When your primary state of residence is a compact state other than Missouri, your Missouri license will be placed on inactive status and you can practice in Missouri based on your unrestricted multi-state license from another compact state.

I solemnly declare and affirm, that I am the person who is referred to in the foregoing declaration of primary state of residence; that the statements therein are strictly true in every respect, under the pains and penalties of perjury.

→_____ _____
Signature ***(This form must be signed)*** Date

Complete, SIGN and Return to the Missouri State Board of Nursing, PO Box 656, Jefferson City, MO 65102 Or Fax to 573-751-6745 or Scan and Email to nursing@pr.mo.gov

Moments with Marcus

Marcus Engel

As I'm writing this, it's early December and everyone is in the holiday spirit. For us, it started on December 1 when my entire family (grandkids and all) went to New York City to do the classic Christmas tour. It also happened to be the birthday of The Hotness, so it was celebration central!

As our wide-eyed throng of seven adults, one kindergartener and a three-month-old stepped out of the subway, we witnessed something disturbing: A man fighting with a light pole. True 'bare-knuckle punches on a steel streetlight while screaming obscenities at an inanimate object' kind of fight. This wasn't boxing or play fighting – it was with an intensity and strength that undoubtedly led to broken bones.

We moved the six-year-old and baby to the middle of our crowd, and carried on.

Friends, there wasn't a single thing I could do to help this man. Whatever mental illness plagued him is out of my area of expertise. There are meds that could help, but I can't prescribe those and, even if I could, no one could force him to take them. This is a pretty helpless feeling… and one which, I'm sure that you, Faithful Reader, have had, too.

Had this man not been in a knock down, drag out fight with the street light, he could have passed by us undetected like the other eight million New Yorkers. But, that behavior was just too obvious. This caused me to think about an event just a few weeks before our New York trip.

In mid-November, I had the pleasure of attending the *Missouri March of Dimes Nurse of the Year Awards Banquet* (which happens to include several counties in Illinois as well!). Finalists in the 20 different categories were recognized and winners announced. My two favorite nurses, Barb and Jenny, were both finalists in their respective categories, but I was also excited to hear about the great work of other exceptional nurses.

The first *Nurse of the Year Award* was in the category of behavioral health and the winner was Dr. Mary Ann Boyd, professor emerita at Southern Illinois University-Edwardsville. In her acceptance speech, Dr. Boyd first thanked the March of Dimes for including the category of behavioral health.

I think the average lay person usually thinks of nursing in an acute care setting. Or maybe nurses working in a long-term care facility. Or maybe in a clinic. But, I don't think the average Joe on the street usually thinks of nursing in relation to behavioral health.

But, when you work in any type of healthcare, you see the challenges of mental illnesses, up close and personal. It may not be the whole reason the patient is before you, but it's often a determining aspect.

No, there was nothing I could have done to help that man on the streets of New York, it left me feeling sad and helpless… Then, I remembered Dr. Boyd's work.

There IS help. It comes from nurses like Dr. Boyd. And you. As we raise awareness of the importance of behavioral health, we are taking the brain and mind into account as we have done with the visible, tangible body.

Treating all three; body, brain and mind can be tricky… and you all do it. Every day. Nurses, you are the face of compassion for some of the most vulnerable members of our community. Your presence, your skill, your awareness, your humanity… these are all essential in treating the whole patient. Thank you for remembering individuals are just that. And, thanks to the March of Dimes for recognizing these nursing heroes, too. Congratulations to all the winners and finalists who exemplify the heart of nursing!

Disciplinary Actions**

Pursuant to Section 335.066.2 RSMo, the Board "may cause a complaint to be filed with the Administrative Hearing Commission as provided by chapter 621, RSMo, against any holder of any certificate of registration or authority, permit, or license required by sections 335.011 to 335.096 or any person who has failed to renew or has surrendered his certificate of registration or authority, permit or license" for violation of Chapter 335, the Nursing Practice Act.

**Please be advised that more than one licensee may have the same name. Therefore, in order to verify a licensee's identity, please check the license number. Every discipline case is different. Each case is considered separately by the Board. Every case contains factors, too numerous to list here, that can positively or negatively affect the outcome of the case. The brief facts listed here are for information only. The results in any one case should not be viewed as Board policy and do not bind the Board in future cases.

The Board of Nursing is requesting contact from the following individuals:

Brandi L Findley – PN 054041
Amanda Carla Franz – PN 2014004807
Janet L Hollands – RN 2000144391
Angela Leigh King – RN 2010025942
Tiffany Nichole Meyers – PN 2005041268
Cassandra Lynn Wilmes – RN 201002609

If anyone has knowledge of their whereabouts, please contact Kristi at 573-751-0082 or send an email to nursing@pr.mo.gov

CENSURE

Lennon, Natalie Kay
Savannah, GA
Registered Nurse 2016033478
Licensee submitted an application dated October 25, 2016, that indicated she had received a "BSN" from the College of Coastal Georgia on her application. Further, Licensee submitted a fraudulent diploma purportedly issued by College of Coastal Georgia to Aureus in an attempt to be hired under the pretense of being a BSN Registered Nurse. Aureus verified Licensee's education with College of Coastal Georgia and discovered that Licensee had received an Associates degree and not a Bachelors degree from the College and that Licensee had submitted a fraudulent diploma to Aureus. Licensee was enrolled in classes to obtain her "BSN," but had not obtained her "BSN" at that time. Licensee admitted to the Board Investigator that she had not graduated from a "BSN" program and had made the diploma herself in order to obtain a travel job with Aureus.
Censure 11/17/2017

Ellison, Cassandra Anne
Carl Junction, MO
Registered Nurse 2014040224
Licensee misrepresented patient information by documenting assessments she had not performed and using past information. Licensee misrepresented a patient's chart by documenting that a skin assessment had been witnessed when it had not been witnessed.
Censure 09/13/2017

Oligschlaeger, Tammy J
Mexico, MO
Registered Nurse 2015007702
On or about March 1, 2016, Licensee entered the room of a minor patient to obtain a urine sample. The patient refused and eventually struck Licensee in the face. Licensee then, with the assistance of hospital security, restrained the patient without first securing a doctor's order, although she subsequently secured such an order.
Censure 10/31/2017

Higgerson, Paula C
New Madrid, MO
Licensed Practical Nurse 2008028843
On November 14, 2016, Licensee called a pharmacy and requested a prescription for Adipex to be filled for her mother. The pharmacy technician wrote the name of the physician incorrectly, which caused the pharmacist to contact the physician who had previously written prescriptions for mother. The physician advised the pharmacy to not fill that prescription, as he had not written that prescription. When questioned by medical office officials, Licensee acknowledged that she had called in the Adipex prescription for her mother. She stated she did so because her mother's prescription had expired. Licensee did not have authorization from the prescribing physician to call in a prescription for her mother.
Censure 09/07/2017

Bernholtz, Cathy Jo
Kearney, MO
Licensed Practical Nurse 2001018535
Licensee practiced nursing in Missouri without a license from June 1, 2016 to September 26, 2017.
Censure 11/04/2017

Stanley, Cody Nathan
Dexter, MO
Licensed Practical Nurse 2015000379
Respondent failed to check in with NTS on three (3) days. Further, on December 8, 2016; June 13, 2017; June 22, 2017; and July 7, 2017, Respondent checked in with NTS and was advised that he had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on October 20, 2016, Respondent failed to check in with NTS; however, it was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on October 20, 2016. The Board did not receive an employer evaluation or statement of unemployment by the quarterly due dates of January 6, 2017 and July 6, 2017.
Censure 09/22/2017

McElfresh, Jennifer Michelle
Lake Saint Louis, MO
Registered Nurse 2005023515
On or about November 30, 2016, Licensee wrote and signed two prescriptions using the prescription pad of her supervising physician at the spa, for someone who did not receive primary care at the spa, but who was a patient at a different facility where Licensee worked that was not connected with Dr. S.L. The prescriptions were for sixty 0.5 mg alprazolam pills with three refills and for thirty 20 mg Adderall XR pills with unlimited refills. The supervising physician had not approved Licensee to write the prescriptions in question and would not have authorized Licensee to write prescriptions for alprazolam or Adderall through the spa. Pursuant to 20 CSR 2200-4.200 (3)(G)7, any prescription written by Licensee must have the name, address, and telephone number of both the collaborating physician and the APRN on it. The prescription pad used by Licensee contained only the information of her supervising physician with her signature. Pursuant to 335.019 RSMo, Licensee is to be deemed eligible to prescribe controlled substances by the Board, and then obtain approval from the Bureau of Narcotics and Dangerous Drugs (BNDD) and the Drug Enforcement Administration (DEA) before being legally authorized to prescribe controlled substances. Licensee does not have controlled substance prescriptive authority from the Board or approval from the BNDD or DEA.
Censure 11/04/2017

Disciplinary Actions**

Poynter, Jason Michael
Saint Louis, MO
Licensed Practical Nurse 2014022342
On July 27, 2015, Licensee pled guilty to the offense of Driving While Under the Influence of Alcohol in the Circuit Court of Fayette County, Illinois. Licensee had two (2) previous driving while intoxicated offenses in November 2007 and October 2008.
Censure 10/31/2017

Kerns, Mary Ann
O Fallon, MO
Registered Nurse 128192
On December 22, 2015, Licensee documented the waste of a 2mg/ml vial of Dilaudid; however, the nurse who was documented as wasting with Licensee stated to officials that she did not recall observing the waste of the narcotic. A review of Licensee's diversion reports identified a consistently higher than normal standard deviation for Dilaudid administration by Licensee. During December 2015, Licensee withdrew Dilaudid three times and did document the administration or waste. On December 22, 2015, Licensee withdrew Dilaudid 2 mg for patient C.P. at 15:46, however, Licensee failed to document the administration or waste of the medication. On December 22, 2015, Licensee withdrew Dilaudid 2mg for patient C.B. at 7:57, however, Licensee failed to document the administration or waste of the medication. She indicated that she had returned the Dilaudid to Pyxis, however, the Dilaudid wasn't found. On December 22, 2015, Licensee withdrew Dilaudid 4 mg and Fentanyl 110 mcg for patient N.C. at 17:23; however, she failed to document the administration or waste of 1.5 mg of Dilaudid and 100 mcg of Fentanyl.
Censure 11/07/2017

Harvey, Kelly S
Carrollton, MO
Registered Nurse 137676
Licensee practiced nursing in Missouri without a license from May 1, 2015, to April 18, 2017.
Censure 09/07/2017

PROBATION

Kean, Patricia A
Columbia, MO
Registered Nurse 139093
In February 2015, Respondent called a pharmacy and requested prescriptions for herself for Lasix and Klor-Con. Respondent called in the prescriptions using the name of her collaborating physician. Respondent called in the prescriptions for herself prior to consulting her collaborating physician. During February 2015, Respondent prescribed Phentermine for her daughter. Phentermine is a controlled substance.
Probation 09/07/2017 to 09/07/2018

Chamblin, Barbara Josephine
Shawnee Mission, KS
Registered Nurse 133451
Licensee's license expired on April 30, 2015. On or about August 20, 2017, Licensee learned her license had expired on April 20, 2015. Licensee informed her employer on August 21, 2017, and removed herself from her nursing position until the Board renewed her license. Licensee practiced nursing in Missouri without a license from May 1, 2015, through August 20, 2017.
Probation 11/28/2017 to 11/28/2018

Fortner, John Bruce
Poplar Bluff, MO
Registered Nurse 2009008074
Licensee was scheduled to be on-call as the nurse anesthetist from 7:00 p.m. to 3:00 a.m. on March 23, 2017. On March 23, 2017, at approximately 10:35 p.m., the hospital was notified that staff was unable to reach Licensee about a patient needing an epidural. The House Manager responded to the on-call room, where Licensee was sleeping, and knocked several times. When Licensee failed to answer the door, the House Manager opened the door with the key and entered the room. Licensee was found lying in bed with his street clothes on. The House Manager had to "holler" at Licensee a few times and then Licensee rolled over. Licensee's speech was slurred and he was unable to sit up straight. A mostly empty bottle of spiced rum was found next to the bed. When questioned, Licensee admitted that he had been drinking alcohol and was intoxicated. On a breathalyzer test, Licensee blew .186 initially and .172 seventeen minutes later.
Probation 10/13/2017 to 10/13/2022

Griggs, Matthew Ryan
Kansas City, MO
Registered Nurse 2015024684
Licensee was found falling asleep at the nurse's station. When the oncoming nurse was receiving report, Licensee had slurred speech and was not steady on his feet. One of Licensee's patients was found in restraints; however, there was no documentation or an order for the restraints in the patient's chart. Licensee was asked to submit to a for cause drug screen. The sample which Licensee submitted returned positive for Marijuana and Benzodiazepines, on February 22, 2016. Licensee admitted to the Board's investigator that he had smoked marijuana approximately one month before the incident. Further, Licensee admitted that he had taken his wife's alprazolam for anxiety.
Probation 11/24/2017 to 11/24/2022

Kennedy-Nowicki, Elizabeth Marie
Grover, MO
Registered Nurse 2017032068
Licensee was previously licensed by the Missouri Board as a registered professional nurse, license number RN 2000158817. Her license was originally issued on June 19, 2000, was placed on probation by the Board on August 31, 2011, and was voluntarily surrendered on December 1, 2011. Licensee pled guilty to the class B felony of production of

PROBATION continued on page 12

Disciplinary Actions**

PROBATION continued from page 11

a controlled substance on November 12, 2010. Licensee reports that she received treatment from January 2011-April 2011, as ordered by the court. Licensee also reports that she again received treatment from November 2012-April 2013, as ordered by the court due to testing positive for marijuana. During treatment, Licensee was diagnosed with cannabis dependence, and it was recommended that she continue recovery support and outpatient psychiatric care. Licensee received a substance abuse evaluation on April 13, 2017, which stated that no further treatment was needed.
Probation 09/05/2017 to 09/05/2020

Brown, Jacqueline S
Monroe City, MO
Licensed Practical Nurse 057757
On November 3, 2014, Respondent pled guilty to the class A misdemeanor of Theft/Stealing. On April 5, 2016, Respondent pled guilty to the class A misdemeanor of Accessory - Theft/Stealing.
Probation 09/07/2017 to 09/07/2019

Marler, Karmen M
Patterson, MO
Licensed Practical Nurse 054739
Licensee indicated that she had worked while her license was expired. Licensee reported that she worked as a licensed practical nurse from December 2, 2008, until September 22, 2016. Licensee practiced nursing in Missouri without a license from June 1, 2010, through September 22, 2016.
Probation 09/05/2017 to 09/05/2020

Heuser, Crystal Lynn
Bolivar, MO
Registered Nurse 2010022779
On February 26, 2015, Respondent received a plan of correction from the hospital regarding documentation issues and the management of her time spent assessing patients. Respondent was taken off the plan of correction in May 2015. In August 2015, hospital officials reinstated the plan of correction for further issues exhibited by Respondent regarding reassessing acute patients and compliance in assuring medication orders were entered correctly. During an audit of narcotic administration, hospital officials discovered that Respondent had withdrawn Fentanyl 100mcg for IVP on three separate occasions for the same patient, once on July 31, 2015 at 15:52 and twice on August 1, 2015 at 10:35 and 12:59. The dose ordered each time was 12.5 mcg; Respondent documented those doses as administered. Respondent did not document the administration, waste, or return of the remaining 262.5 mcg of Fentanyl.
Probation 09/07/2017 to 09/07/2018

Benfield, Marilyn Rose
Bonne Terre, MO
Registered Nurse 2000158988
Respondent failed to check in with NTS on nine (9) days. Further, on October 6, 2016, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on September 9, 2016, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On April 14, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. On April 20, 2017, Respondent submitted a urine sample for random drug screening. The sample tested positive for the presence of Butalbital. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of October 13, 2016.
Probation 09/07/2017 to 09/07/2020

Davis, Jamie Lea
Cole Camp, MO
Registered Nurse 2009008888
On or about February 8, 2016, the Board received a complaint regarding the nursing license of Licensee. On or about January 9, 2016, the medication room supervisor notified the Director of Nursing that there was some Strattera medication unaccounted for. As there were no patients in the facility currently taking Strattera, there was no reason for any nurse to withdraw the Strattera medication. The Medication Room Supervisor recalled an issue on December 12, 2015, with missing Strattera. Therefore, the Medication Room Supervisor was instructed to count the Strattera medication on a daily basis. On January 11, 2016, at approximately 1030, a count was done of the Strattera. A count was again done January 12, 2016 at approximately 1100. There was one 25 mg tablet of Strattera and one 20 mg tablet of Strattera missing. A search was conducted through the medication room cameras for the period of January 11, 2016 at 1030, through January 12, 2016 at 1100. Officials reviewed security video showing that at approximately 2135 on January 11, 2016, and 0218 on January 12, 2016, Licensee took 25 mg tablet of Strattera and one 40 mg tablet of Strattera from the medication box. On January 13, 2016, the Director of HR Administration and the Assistant Director of Nursing met with Licensee and questioned her about the missing Strattera. Licensee admitted to taking the two missing Strattera tablets for another employee, but would not name the employee. Licensee further stated that she has pulled Strattera for the other employee "May[be] a couple of times. I wouldn't think over five times."
Probation 11/28/2017 to 11/28/2022

Paden, Charlsey Nichole
Richmond, MO
Registered Nurse 2012008784
On April 6, 2017, the Board received a complaint reporting the termination of Licensee due to accepting a monetary

Disciplinary Actions**

gift from a client's family member and for testing positive for marijuana. On or about March 29, 2017, Licensee was involved in a car accident after leaving a patient's home. A routine drug screen following the car accident was positive for marijuana. In March 2017, it was reported to Phoenix administrators that a client's family member sent Licensee a "thank you" card and $100 for appreciation of the care and assistance provided to the client. Licensee admitted to providing her home address to the client's sister so she could send a thank you card, which violates professional boundaries.
Probation 11/28/2017 to 11/28/2022

Tomlinson, Tara Liane
Florissant, MO
Registered Nurse 2003012764
On February 26, 2016, Licensee was asked to submit to a for-cause drug screen, at which time she was suspended from the hospital, pending the results of the drug screen. The drug screen was confirmed positive for marijuana on March 3, 2016.
Probation 10/13/2017 to 10/13/2020

Bruegman, Summer Danielle
Bolivar, MO
Licensed Practical Nurse 2013038545
Patient F.S. reported to the agency that Licensee had not been in her home approximately a week after July 18, 2015. Licensee documented that she visited patient F.S. in her home on or about July 23, 2015. Patient W.M., who lived in the vicinity of patient F.S., stated that Licensee had not been to his home in over a month. On July 9, 2015, July 17, 2015, and July 23, 2015, Licensee documented that she visited patient W.M. Licensee falsely documented that she had assessed the patients. Licensee's record entry constituted falsely documenting her findings.
Probation 09/29/2017 to 09/29/2019

O'Dell, Karen Nadine
Harrison, AR
Licensed Practical Nurse 2008025611
On July 6, 2015, Licensee was witnessed by coworkers going into unassigned work areas and removing the sharps containers. On July 21, 2015, Licensee was witnessed removing a sharps container from a room and then taking the container into the biohazard disposal area for an unusually long period of time. On July 23, 2015, Licensee was questioned by the Assistant Director of Nursing of the facility regarding her behavior; she admitted that she had been removing Fentanyl patches from sharps containers and chewing on them since June 22, 2015.
Probation 09/09/2017 to 09/09/2021

Brown, Karen L
Saint Peters, MO
Registered Nurse 150353
On or about November 2, 2016, Licensee visited a patient's home and provided care. The patient informed Licensee that he was not using some of his pain medications, so Licensee told the patient that she would take his pain medications back to the agency to be wasted. During her visit with the patient, Licensee noted a change in the patient's condition and instructed the patient's mother to take the patient to the hospital for care related to an infection. Upon returning home on November 5, 2016, the patient contacted the agency office stating that Licensee had taken his pain medications from the home and he did not have any pain medications. The medications removed from the home included a Comfort Pak, Dilaudid tablets, liquid Morphine, and MS Contin tablets. The medications Licensee removed from the patient's home were not wasted at the agency office. The agency's policy is to not remove medications from a patient's home, but to waste the medications in the patient's home. Licensee was observed at the agency office on November 3, 2016 in an impaired state. Licensee was observed with glazed eyes, slurred speech, and being unable to write her name legibly or hold a coherent conversation. Licensee was asked to submit a sample for a for-cause drug screen. Licensee submitted a sample for screening on November 3, 2016. The sample which Licensee submitted returned positive for Oxycodone, Oxymorphone, Hydromorphone, and Morphine.
Probation 10/12/2017 to 10/12/2022

Simons, Daniel Morgan
Spokane, MO
Registered Nurse 2014021005
The audit showed that the Licensee did not properly document the administration, waste, or return of several controlled substances from April 2016 through June 2016. On multiple occasions Licensee failed to document the administration, waste, or return of fentanyl, morphine and lorazepam. Licensee failed to properly document the administration, waste, and return of multiple controlled substance medications. Accurate documentation related to medication administration is an essential function of being a nurse, as poor documentation can jeopardize patient health and safety. Licensee was asked to submit a sample for a for-cause drug screen; however, Licensee did not provide a sample for hospital officials. Licensee was terminated from the hospital on June 15, 2016, for failing to submit to a for-cause drug screen.
Probation 09/20/2017 to 09/20/2022

Stadler, Louis Joseph
Jenks, OK
Registered Nurse 2010008003
From May 24, 2017, until the filing of the Complaint on July 11, 2017, Respondent failed to check in with NTS on three (3) days. On June 27, 2017, Respondent reported to a collection site to provide a sample, and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol.
Probation 09/07/2017 to 09/07/2022

PROBATION continued on page 14

Disciplinary Actions**

PROBATION continued from page 13

Bonham, Erin Renee
Bakersfield, MO
Registered Nurse 2009032627
Licensee worked as a nurse in Missouri without a license from May 1, 2017 until June 16, 2017. This is the second time that Licensee has worked without a valid license, having done so from May 1, 2011 through February 8, 2012 previously.
Probation 10/05/2017 to 10/17/2017

Pearson, Dale Allen
Bloomfield, MO
Licensed Practical Nurse 2008023282
On October 11, 2016, Respondent was working at the facility as the only nurse on duty from 10:00 p.m. to 6:00 a.m. At approximately 11:40 p.m., the facility's Director of Nursing Services was informed by facility staff that Respondent had left the building. Respondent did not return to the facility for approximately one hour. Respondent abandoned his patients for approximately one hour. On October 21, 2015, Respondent pled guilty to the class C felony of Possession of a Controlled Substance. Respondent possessed methamphetamine and used methamphetamine.
Probation 09/07/2017 to 09/07/2022

Shy, Janet Rebekah
Desloge, MO
Licensed Practical Nurse 037659
From May 24, 2017 through the filing of the Complaint on June 30, 2017, Respondent failed to check in with NTS on two days. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf by the documentation due date of June 12, 2017.
Probation 09/05/2017 to 11/27/2017

Grant, Cymica G
Belleville, IL
Registered Nurse 2011003658
On March 7, 2013, Respondent pled guilty to the offense of Embezzlement of Public Funds due to Respondent knowingly receiving excessive unemployment monies.
Probation 09/07/2017 to 09/07/2018

Evans, Colleen Marie
Desloge, MO
Registered Nurse 2011023484
The Administrator discovered that there were missing narcotic count sheets, missing medications, and a failure to follow the proper practices and systems by Licensee. On July 29, 2014, Licensee was requested to submit a sample for drug and alcohol screening. Licensee initially agreed to provide the sample, but declined to provide a sample when at the collection site. It was discovered that Licensee had charted that 22.00 ml of Roxanol for patient DD had been disposed of; however, Licensee did not have a second nurse sign off on the disposal as required. Licensee was the last person in possession of the medication and she failed to properly document what happened to the medication. It was discovered that on June 3, 2014, Licensee had charted that 18.75 ml of Roxanol for patient DD had been disposed of; however, Licensee did not have a second nurse sign off on the disposal as required.
Probation 11/24/2017 to 11/24/2018

Oliver, Franci Leigh
Springfield, MO
Registered Nurse 2003028626
On or about September 15, 2016, a patient reported that he had not received a pain medication, Oxycodone, which Licensee had documented as administered. Licensee was asked to submit to a for cause drug screen. The sample which Licensee submitted returned positive for oxycodone and oxymorphone, on September 19, 2016. Licensee admitted she had taken her father's prescription of Percocet which is a name brand of oxycodone. Licensee did not have a prescription for, or a lawful reason to possess, oxycodone or oxymorphone.
Probation 11/24/2017 to 11/24/2022

Cuestas, Theresa Marie
Bowling Green, MO
Licensed Practical Nurse 2010029473
On April 27, 2016, correctional facility custody staff received an anonymous note alleging that Licensee was engaging in an unauthorized relationship with an offender. An investigation into the situation revealed the offender and Licensee had exchanged letters, photographs, and multiple telephone calls and that Licensee and the offender had kissed while he was in the medical cell. Licensee acknowledged she had violated facility policy by having an inappropriate relationship with the offender.
Probation 10/12/2017 to 10/12/2018

Franklin, Mary Frances
Kidder, MO
Licensed Practical Nurse 2017034764
On May 7, 2013, Applicant pled guilty to the class A misdemeanor of passing a bad check. Applicant's plea of guilty to passing a bad check, under these circumstances, is an offense for which fraud and dishonesty are essential elements and is an offense involving moral turpitude giving cause to deny Applicant's application for licensure.
Probation 09/26/2017 to 09/26/2022

Mindingall, Ubah A
Independence, MO
Registered Nurse 2005030330
The Missouri State Board of Nursing received information from the Arizona Board of Nursing that Respondent was denied initial licensure in the State of Arizona in an Order of Denial (Order) dated March 23, 2017. In the Order, Respondent was also ordered to cease and desist the practice of nursing in Arizona using her Nurse Licensure Compact privilege to practice.
Probation 09/22/2017 to 09/22/2018

Nurmela, Sherry M
Valley Park, MO
Registered Nurse 148373
Licensee worked as a nurse in Missouri without a license from May 1, 2017 until July 13, 2017. This is the second time that Licensee has worked without a license having done so previously from May 1, 2011 through June 10, 2011 without a license
Probation 10/05/2017 to 10/26/2017

Irwin, Tracy L
Affton, MO
Registered Nurse 2007011285
As part of the renewal process, Licensee was required to complete a chemical dependency packet. In the packet, Licensee reports that she was terminated from her employer in 2012 for suspicion of drug use and diversion. She also reports that in March 2015, she was terminated from another place of employment due to diverting medications. On July 8, 2015, Licensee pled guilty to the offense of petty larceny in the Municipal Court of Creve Coeur, Missouri. Licensee received a suspended imposition of sentence with two years of probation. Licensee reports that this charge was related to her diverting medication from her employer. Licensee reports that she voluntarily admitted herself to The Watershed Addiction Treatment Program on three separate occasions: September 29, 2014 until October 1, 2014; October 3, 2014 until October 16, 2014; and October 16, 2014 until December 1, 2014. Licensee was diagnosed with opiate dependence and sedative dependence. She successfully completed the prescribed treatment interventions. Licensee reported that she used/abused heroin, Dilaudid, Vicodin, and temazepam. Licensee states that her sobriety date is June 23, 2015, and she attends Narcotics Anonymous meetings twice weekly. She has had a sponsor for the past two years. Licensee received a substance abuse evaluation on June 27, 2017, which recommended continued bi-weekly narcotics anonymous meeting attendance, daily communication with her sponsor, and drug testing.
Probation 11/28/2017 to 11/28/2021

Winkelmann, Tonya D
Ellisville, MO
Registered Nurse 2007000552
On March 8, 2017, Respondent pled guilty to the class A misdemeanor of Identity Theft or Attempt, in violation of õ570.223 RSMo, in the Circuit Court of Cole County, Missouri, in case number 15AC-CR02792.
Probation 09/07/2017 to 09/07/2018

Radford, Lynnette Kay
Lampe, MO
Registered Nurse 2017041615
On or about August 28, 2015, the Kansas Board of Nursing issued its Proposed Default Order revoking Licensee's Kansas nursing license, effective September 8, 2015. In the original Petition, the Kansas Board found that Licensee had been repeatedly negligent in the care of patients and had failed to follow policies and procedures designed to safeguard the patients, which is cause for discipline in this State for repeated negligence pursuant to õ335.066.2(5) RSMo. On February 7, 2017, the Colorado Board of Nursing issued its Stipulation and Final Agency Order allowing Licensee to practice in the state of Colorado under a probated license due to the revocation of her Kansas license. The Colorado Order placed Licensee's Colorado license on probation for a period of two (2) years under specified terms and conditions. On March 31, 2017, the Kansas Board of Nursing issued its Consent Agreement and Final Order reinstating Licensee's Kansas nursing license with specified stipulations.
Probation 11/28/2017 to 11/28/2019

Mccrae, Ida J
Doniphan, MO
Registered Nurse 086500
During the period from April, 2013, through July, 2013, licensee wrote out prescriptions for Tramadol for her son who has traumatic injuries. These prescriptions were used by him. Some or all of these prescriptions were picked up at the pharmacy by licensee. Licensee on at least one occasion signed her name upon pick-up as "Ida Smock," a name she has been known by in the area. Officials were notified and began an investigation and noted that the son's medical chart did not show the prescriptions. Licensee was requested to submit to a drug screen and the sample tested positive for barbiturates, but licensee had a valid prescription for Fioricet at that time and Fioricet contains barbiturate.
Probation 11/24/2017 to 11/24/2020

Dewein, Rebecca A
Florissant, MO
Registered Nurse 145452
COUNT I: At all times relevant to Count I, Licensee was working in the hospital's Cardiac Cath Lab. On multiple occasions license did not chart the administration, waste, or return of Fentanyl and Midazolam. COUNT II: Licensee was employed by a second hospital from August 26, 2013 through December 3, 2013. On November 11, 2013, Licensee withdrew two 100 mcg vials of fentanyl for a patient. 75 mcg of fentanyl were charted as administered to the patient, and 25 mcg of fentanyl were charted as wasted. Licensee failed to chart the administration, waste, or return of 100 mcg of Fentanyl. On November 14, 2013,

Disciplinary Actions**

hospital administrators requested that Licensee submit a urine sample for a for cause drug test. The sample Licensee submitted tested positive for fentanyl.
Probation 09/12/2017 to 09/12/2020

Koch, Amie Marie
Chaffee, MO
Licensed Practical Nurse 2011034034
On May 11, 2017, Respondent pled guilty to the class C felony of Possession of a Controlled Substance Except 35 Grams or less of Marijuana.
Probation 09/07/2017 to 09/07/2022

Myers, Natasha Rae
Hannibal, MO
Licensed Practical Nurse 2004025472
On November 1, 2011, Licensee pled guilty to the class B misdemeanor of driving while intoxicated. On November 6, 2013, Licensee pled guilty to the class B misdemeanor of driving while intoxicated. Licensee has completed alcohol treatment three times since 2010. On November 13, 2014, Licensee pled guilty to the class A misdemeanor of driving while intoxicated. Licensee stated to the Board that she does not attend support group meetings, does not have a sponsor, and does not have a sobriety date. Effective December 11, 2013, a five (5) year denial was placed on Licensee's Missouri driver's license by the Missouri Department of Revenue as a result of alcohol being involved while operating a motor vehicle. On May 28, 2013, Licensee's driver's license received an administrative alcohol revocation. On June 20, 2011, Licensee's driver's license received an administrative alcohol suspension. On June 24, 2002, Licensee's driver's license received an administrative alcohol suspension.
Probation 11/24/2017 to 11/24/2022

Manar, Patricia Starr
Smithville, MO
Licensed Practical Nurse 2014030164
On June 15, 2016, a patient's mother contacted the agency regarding Licensee leaving her home before the end of the scheduled shift. Further, the patient's mother informed agency officials that Licensee had left early on June 14, 2016, and had not worked her assigned shift on June 8, 2016. Licensee had submitted timesheets signed by the patient's mother for all three dates and alleging that Licensee had completed the full scheduled shifts. The patient's mother stated that she did not sign the time sheets for the dates and times indicated on June 8, 2016, June 14 and 15, 2016. Licensee submitted a timesheet and progress notes for the patient indicating that she had been caring for the patient on June 8, 2016, from 0700 until 1700. Licensee documented that she had administered medications at 0800 and 1000, performed a patient assessment at 0800, performed a patient feeding at 1100, and that the patient went to camp at 0930. Licensee later admitted to the Board's investigator that she had written the progress notes the previous day and stated she had not gotten to the patients home until 12:00 p.m.
Probation 11/21/2017 to 11/21/2018

Sanai, Laura M
Kansas City, MO
Registered Nurse 146422
In January 2015 an audit was performed on Licensee's narcotic usage at the hospital, and multiple discrepancies were noted. When questioned by hospital administration about the discrepancies, Licensee admitted that she had diverted oxycodone on several different occasions. Licensee was employed as a registered professional nurse at another hospital. On January 14, 2016, Licensee was witnessed by a coworker removing a bag of medication from the pharmacy technician's drug restocking cart. The medication bag contained controlled substances under õ195.017 RSMo., including Methadone vials, hydrocodone pills, oxycodone pills, diazepam injection cartridges, fentanyl syringes, lorazepam vials, and morphine syringes. Licensee admitted to her supervisor that she had taken the bag of medications from the pharmacy technician's cart. Licensee took possession of controlled substance medications which she had no valid reason to possess. An audit of Licensee's medication administrations was also run. On five (5) occasions, Licensee withdrew controlled substance medications and failed to properly document the administration, waste, or return of the controlled substance medication.
Probation 11/21/2017 to 11/21/2021

Winn, Jeffery Allen
Saint Louis, MO
Registered Nurse
On January 14, 2016, Respondent pled guilty to three counts of the offense of False Statements Relating to Health Care Matters.
Probation 09/11/2017 to 09/11/2018

Little, Mykhaele Aleasean
Columbia, MO
Licensed Practical Nurse 2007030896
On February 11, 2017, after Licensee had provided care for patient H.F., patient H.F. was admitted to the Emergency room for being unresponsive and having bradycardia. On February 13, 2017, after Licensee had provided care for patient H.F., patient H.F. was admitted to the Emergency room for being unresponsive and having bradycardia. It was discovered that on both days, Licensee had removed an unmarked syringe of Clonidine from the refrigerator at the patient's home and administered it to the patient. Licensee stated she thought that the unmarked syringe contained the patient's probiotic. Licensee admitted that she administered the contents of an unmarked syringe to patient H.F. on two (2) occasions.
Probation 09/20/2017 to 09/20/2018

Stewart, Melissa Kathleen
Osceola, MO
Licensed Practical Nurse 2011000748
In October 2012, DON reviewed pharmacy delivery/check-in sheets and discovered that the nursing home had received tramadol, a pain medication, for a resident who did not have a physician's order to receive it. After DON reviewed the pharmacy and medical records, she determined that Respondent had ordered tramadol from the pharmacy for three residents who did not have a physician's order for tramadol. Respondent ordered approximately 900 pills of tramadol in total for the three nursing home residents during the four-month period. Respondent admitted that she ordered the tramadol for the three residents without a physician's order and removed the medication from the facility.
Probation 09/05/2017 to 09/05/2022

Muenks, Scott Francis
Jefferson City, MO
Registered Nurse 2008020788
On or about May 5, 2017, the Board received a complaint against the nursing license of Applicant from Fulton Medical Center (Fulton).
Fulton reported that Applicant was terminated from the facility due to suspicion of tampering with four (4) vials of Dilaudid and three (3) vials of Demerol.
On April 24, 2017, Fulton administrators became aware that four (4) vials of Dilaudid were found in the Pyxis drawer missing the protective caps and had the aluminum cap that secured the rubber stopper to the vial appeared to be glued.
The four (4) vials of Dilaudid were sent to the lab for testing and were found with no identifiable trace of the drug remaining in the fluid. The vials contained liquid that appeared to be either water or saline.
Applicant was found to be the only nurse who accessed that particular Pyxis drawer between March 31, 2017 and April 24, 2017, with no supporting patient administration activity.
On April 27, 2017, Fulton administrators became aware that three (3) vials of Demerol were missing their caps and the caps were laying in the bottom of the Pyxis drawer.
The three (3) vials were sent to the lab for testing and were found to have only a trace amount of Demerol remaining in the contents of the vials of fluid, which appeared to be either water or saline.
The investigation indicated that Applicant accessed the Demerol Pyxis drawer on January 1, 2017 and then cancelled the transaction. Applicant additionally accessed the drawer on two (2) occasions on February 3, 2017, without any documentation of administration or waste.
Applicant admitted to the Board's investigator that he diverted the Dilaudid and Demerol from Fulton for his personal use.
Renewal Denied 11/28/2017

REVOKED

Marsh, Melissa Dawn
West Plains, MO
Registered Nurse 2012017773
From February 17, 2017, until the filing of the Complaint on July 12, 2017, Respondent failed to check in with NTS on one (1) day. Further, on April 25, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on six (6) separate occasions, February 20, 2017; April 10, 2017; May 8, 2017; May 19, 2017; May 30, 2017; and June 16, 2017, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. A creatinine reading below 20.0 is suspicious for a diluted sample. On May 19, 2017, and June 16, 2017, Respondent submitted a urine sample for random drug screening. Both samples tested positive for the presence of marijuana. The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 8, 2017.
Revoked 09/05/2017

Smith, Keanan Sean
Belleville, IL
Licensed Practical Nurse 2004034001
The Board did not receive an employer evaluation or statement of unemployment by the documentation due dates of March 13, 2017 and June 12, 2017.
Revoked 09/05/2017

REVOKED continued on page 16

Disciplinary Actions**

REVOKED continued from page 15

Dorsey, Meghan Rose
Norfolk, VA
Licensed Practical Nurse 2010005424
On November 8, 2016, Respondent pled guilty to the class D felony of Fraudulently Attempting to Obtain a Controlled Substance by Fraud or Deceit.
Revoked 10/05/2017 to

Shank, Lisa K
Arnold, MO
Licensed Practical Nurse 049477
COUNT I: On November 9, 2014, Respondent provided care for patient AE. After Respondent's shift on November 9, 2014 it was reported that Respondent could barely stand and had to hold onto the wall to keep from falling; Respondent appeared to be falling asleep while standing and talking; had red, watery eyes and made frequent trips to the bathroom; did not give patient AE all of her scheduled medications or her bolus; and, Respondent failed to document all care provided and Respondent's nursing notes were not legible. On November 12, 2014, Respondent did not complete a patient assessment for patient E.B. Respondent, in her narrative regarding patient EB's care, stated that the patient is able to communicate simple answers. However, patient EB is nonverbal and unable to give simple answers. Respondent also noted that they attended a holiday party; however, there was no holiday party during her shift with the patient. The Nurse Manager of the agency stated that during a meeting with Respondent on November 17, 2014, Respondent showed signs of impairment such as having trouble pulling her chair out to sit down, failing to make eye contact, breathing heavily, leaning on the table during the meeting, holding her head up with her hands, consistently moving very slowly, disoriented in answering questions, and stumbling and almost walking into a desk. After the meeting, Respondent was observed drinking a bottle of alcohol in her car. COUNT II: On June 20, 2015, the nursing home DON was notified that a card of hydrocodone pills and the sign out sheet for the card were missing. On July 1, 2015, Respondent was interviewed by the police department and confessed to taking the hydrocodone pills. On March 3, 2016, Respondent pled guilty to unlawful use of drug paraphernalia in violation of õ195.233 RSMo in the Circuit Court of St. Louis County, Missouri in case 15SL-CR05318-01 for possessing a blister pack of hydrocodone with the intent to use it to ingest hydrocodone. On June 23, 2016, Respondent was added to the State of Missouri Department of Health and Senior Services' employee disqualification list for a period of ten years.
Revoked 11/28/2017

Clark, Raeann Kay
Springfield, MO
Licensed Practical Nurse 2001026766
On August 5, 2016, Respondent arrived at work to begin her 2:00 PM to 10:00 PM shift. Respondent began to take report on the patients she was assigned to care for during her shift. Respondent's coworkers observed Respondent to be in an intoxicated condition as she started her shift. Respondent smelled of alcohol, had slurred speech, her eyes were glassy, and she was unable to comprehend the reports she was receiving on her patients. Respondent was also unable to use a key to unlock and open the medication cart. Respondent was asked to submit a sample for a reasonable suspicion drug screening. Respondent refused the drug screen and proceeded to attempt to leave the facility. Respondent was subsequently arrested in the parking lot of the nursing home by the Police Department for driving while intoxicated. A Police Officer searched Respondent's car at the arrest and discovered several open beer cans in the car. On January 19, 2017, Respondent pled guilty to Driving While Intoxicated. Respondent checked into a hospital on August 9, 2016 for treatment of alcohol withdrawal. Respondent was employed by a hospital from September 13, 2004 through March 22, 2016. Respondent's employment with the hospital was terminated on March 22, 2016. Respondent left her work area without reporting to an oncoming nurse, and was found in her car drinking an alcoholic beverage.
Revoked 11/28/2017

League, Heidi Lynn
Lees Summit, MO
Licensed Practical Nurse 2008027500
From July 31, 2017 until the filing of the Complaint on September 21, 2017, Respondent failed to check in with NTS on nineteen days. Further, on August 18, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on August 29, 2017 and September 13, 2017, Respondent failed to check in with NTS; however, these were days that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on August 29, 2017 and September 13, 2017. Pursuant to the terms of the Order, Respondent was required to submit a chemical dependency evaluation to the Board within eight weeks of the effective date of the Order, with a due date of August 21, 2017. The Board did not receive a thorough chemical dependency evaluation submitted on Respondent's behalf. In accordance with the terms of the Order, Respondent was required to undergo a thorough evaluation performed by a licensed mental health professional and have the results submitted to the Board within eight weeks of the effective date of the Order, with a due date of August 21, 2017. The Board did not receive a thorough mental health evaluation submitted on Respondent's behalf.
Revoked 11/28/2017

Lenhardt, Lisa Ann
De Soto, MO
Licensed Practical Nurse 2001026626
The Board did not receive an employer evaluation or statement of unemployment by the documentation due date of June 1, 2017. In accordance with the terms of the Agreement, Respondent was required to meet with representatives of the Board at such times and places as required by the Board. Respondent was advised by certified mail to attend a meeting with the Board's representative on March 7, 2017. Respondent did not attend the meeting or contact the Board to reschedule the meeting. In accordance with the terms of the Agreement, Respondent was required to obtain continuing education hours and have the certificate of completion for all hours submitted to the Board by May 30, 2017. As of the filing of the Complaint, the Board had not received proof of any completed hours.
Revoked 11/28/2017 to

Hornback, Tena M
Sarcoxie, MO
Registered Nurse 120822
From April 6, 2017 through September 22, 2017, Respondent failed to check in with NTS on eight days. On September 14, 2017, Respondent failed to check in with NTS; however, it was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on September 14, 2017. In addition, on four separate occasions, April 21, 2017; August 2, 2017; August 8, 2017; and September 7, 2017, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. A creatinine reading below 20.0 is suspicious for a diluted sample. On September 7, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of amphetamine. Respondent unlawfully possessed amphetamine.
Revoked 11/28/2017

Shy, Janet Rebekah
Desloge, MO
Licensed Practical Nurse 037659
On July 20, 2017 and August 15, 2017, Respondent checked in with NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample on the two days. On August 2, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of methamphetamine.
Revoked 11/28/2017

Disciplinary Actions**

Reynolds, Kimberly S
Saint Joseph, MO
Registered Nurse 156020
On August 31, 2015, co-workers reported that Respondent was speaking loudly and rudely to a coworker at the home while in the presence of nursing home patients. Nursing home administrators received further reports regarding Respondent's rude interactions with coworkers and medication administration concerns. On September 2, 2015, Respondent was sent home at around 12:30 while the nursing home began an investigation into Respondent's conduct. After Respondent had left, the nurse who took over care for Respondent's patients discovered that there was an error for one of the patient's narcotic medication inventory. On September 2, 2015, Respondent documented the withdrawal of one Norco 7.5-325 pill for patient BB at 16:00. Respondent failed to document the administration, waste or return of the pill. Additionally, Respondent had been sent home at 12:30 and could not have withdrawn the medication at 16:00. Nursing home administrators then reviewed Respondent's narcotic medication withdrawals and administrations and several other errors were discovered. On August 31, 2015 Respondent withdrew one Norco 7.5-325 pill for patient CW at 07:30, 11:30, and 16:00 for a total of three pills. Respondent documented the administration of one Norco 7.5-325 pill at 10:40. Respondent failed to document the administration, waste, or return of the remaining two Norco pills. On September 2, 2015, Respondent withdrew one Norco 7.5-325 pill for patient BB at 09:00. Respondent failed to document the administration waste or return of the pill. On September 2, 2015, Respondent documented the withdrawal of one Norco 5-325 pill for patient JS at 09:45. Respondent failed to document the administration, waste or return of the pill. Additionally, patient JS had orders for the Norco medication every six hours. The previous administration was at 06:30, so Respondent's withdrawal was in violation of the orders for the patient. On August 31, 2015, Respondent withdrew two Norco 5-325 pills for patient LH. Only one pill was documented as administered to patient LH. Respondent failed to document the administration, waste or return of the second pill. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case.
Revoked 11/28/2017

Hein, Denise J
Webster Groves, MO
Registered Nurse 074537
On December 5, 2016, Respondent was found guilty of the class A felony of Murder in the Second Degree.
Revoked 09/05/2017

Farris, Elizabeth Ann
Russellville, MO
Registered Nurse 2006034104
On May 11, 2016, three narcotic medications were received at the home and Respondent signed for the delivery from the pharmacy. The three medications were Morphine, Oxycodone, and Zolpidem. Respondent and another nurse attempted to put the medications in an E-Kit but were unable to do so. The nursing home E-Kits are locked storage systems for storing medications. There was a system error in the E-Kit which kept the nurses from adding narcotics to the E-Kit. Respondent and the other nurse agreed to place the narcotic medications in the narcotics box on the medication cart so the narcotics would be under lock and key. Respondent later told nursing home officials that she did not lock the narcotics into the narcotics box, but instead placed the narcotics, unsecured, on top of the medication cart. Respondent did not notify the oncoming shift nurse that the narcotics were left unsecured on the medication cart. Respondent failed to secure narcotic medications which were in her control. When nursing home officials looked for the narcotics the next day, the medications could not be found. All staff members were requested to submit samples for a drug screen due to the missing narcotic medications. Respondent submitted a sample for the for-cause drug screen, on May 13, 2016. Respondent's sample was confirmed positive for Oxymorphone. Respondent did not have a prescription for, or a legal reason to possess, Oxymorphone. Respondent never responded to the investigator and failed to cooperate in the investigation of this case.
Revoked 11/28/2017

Patten, Mary Jo
Warsaw, MO
Registered Nurse 2016043208
Respondent never completed the contract process with NTS. The Board did not receive an employer evaluation or statement of unemployment by the quarterly due dates of March 9, 2017 or June 9, 2017. Respondent did not attend the meeting or contact the Board to reschedule the meeting. She did call the Board and state that she could not attend; however, a subsequent return phone call by the Director of Compliance to her was not returned by Respondent. Respondent has no intention of complying with the probationary terms.
Revoked 09/07/2017

Carter, Mary C
Arnold, MO
Registered Nurse 2013024798
On June 9, 2015 the Director of Pharmacy at the Hospital discovered a large number of suspect transactions in the medication dispensing system (Pyxis). The Director of Pharmacy specifically discovered 2 vials removed that appeared to have been tampered with as well. The vials withdrawn from the Pyxis system had liquid but the seals were broken. Upon investigation, the Hospital staff discovered Respondent accessed hydromorphone on June 9, 2015, but did not administer the drug to any patient. Respondent acquired the Hydromorphone on June 9, 2015, from a floor of the hospital that was closed, with no patients, where she was not working. Respondent admitted to diverting the Hydromorphone. Respondent admitted to ingesting the Hydromorphone. Respondent admitted the vials that were tampered with actually contained saline. The Hospital investigated further and found Respondent had diverted medication on other occasions. Respondent diverted hydromorphone in January 2015. Respondent diverted medication in May 2015, removing Hydromorphone in the medication room at 6:00 a.m. when her shift did not begin until 7:00 a.m. Respondent was witnessed on several occasions wasting Hydromorphone with a witness, but in retrospect the witness did not know for sure that it was Hydromorphone Respondent was wasting. Respondent admitted the diversion of Hydromorphone "started with a wastage and I actually injected." The Hospital found Respondent diverted at least 80 mg. of Hydromorphone. When the Hospital asked Respondent to complete a drug screen on June 9, 2015, Respondent stated the drug screen would be "positive" and that she wanted to resign.
Revoked 11/28/2017

Buzick, Lacey Brooke
Alhambra, IL
Licensed Practical Nurse 2009000392
Count I: The Director of Nursing hired Respondent as a graduate nurse (GN) to work the evening shift as a charge nurse. A GN is a nurse who graduated from a registered nurse (RN) program.[1] In early 2015, Respondent informed Blankenship that she had "passed her boards." Blankenship understood this to mean that Respondent had taken the NCLEX,[2] passed, and was now an RN. After informing Blankenship of this information, Respondent's pay increased to an RN level as opposed to an LPN level of pay. In addition, Blankenship expected Respondent to engage in RN duties, such as managing a PICC line,[3] discontinuing the line, and drawing blood from the line. An LPN cannot perform these duties. Respondent initialed "RN," indicating she was a registered nurse, next to her signature on several documents while employed at the nursing home, including the following documents: A patient's pain assessment tool form on July 1, 2015; A physician's order form on March 27, 2015; and A fall risk evaluation on July 1, 2010.[4] Respondent initialed "GN", indicating she was a graduate nurse, next to her signature on several records while employed at the nursing home, including a controlled drug receipt/record/disposition form on December 12, 2014. At no relevant time did Respondent possess an RN license. Count II: In response to the complaint, facility conducted an investigation and discovered documentation errors wherein Respondent obtained controlled substance tablets, but failed to document that she administered the medication to a patient or wasted the drug. Staff interviewed Respondent regarding the complaint and the failure to initial a medication administration record. Respondent stated she intended to fill out the medication administration record at the end of each of her shifts, but due to her busy schedule, she sometimes forgot. Between January 31, 2016 and February 9, 2016, Respondent documented that she received 17 hydrocodone 5/325 tablets to be administered to patient B.L. She documented receiving the tablets on a controlled substances proof of use form. The form stated, "THE NURSE WHO SIGNS THIS RECORD MUST ALSO SIGN THE SEPARATE MEDICATION ADMINISTRATION RECORD FOR EACH DOSE GIVEN." Respondent did not document the administration, waste, or return of the 17 hydrocodone 5/325 tablets on patient B.L.'s medication administration record. When interviewed, patient B.L. stated she had not received any hydrocodone 5/325 tablets since November 2015. Staff asked Respondent to take a drug screen.

REVOKED continued on page 18

Disciplinary Actions**

REVOKED continued from page 17

Respondent refused, and immediately left the facility and never returned.
Revoked 11/28/2017

Singleton, Ellen C
Auxvasse, MO
Licensed Practical Nurse 056035
On November 12, 2015, Respondent reported to a patient's home to work. After only being at the patient's home for approximately ten minutes, she left. On November 12, 2015, Respondent was called into a meeting with her supervisor to discuss her leaving the clients home after only ten minutes of being there. During the above mentioned meeting, Respondent was witnessed fidgeting, bouncing a lot, and would not make eye contact. On November 12, 2015, Respondent was asked to submit to a for-cause drug screen. On or about November 20, 2015, Respondent's sample returned positive for marijuana, methamphetamine, and amphetamine. Respondent never responded to the Board and failed to cooperate with the Board during the investigation of this case.
Revoked 11/28/2017

Hammond, Lisa Renae
Sikeston, MO
Registered Nurse 2013025426
On or about July 13, 2015, charge nurse A.F removed her medications for a medication pass from Alixa (a medication dispensing system), which then triggered the printing of three (3) narcotic sheets. Charge nurse A.F. went to the printer and saw the three (3) narcotic sheets she printed off as well as three (3) PRN narcotic sheets for residents she had not removed any medications for. Charge nurse A.F. placed the six (6) narcotic sheets in the narcotic book. Respondent approached charge nurse A.F. and asked to have the narcotic book, stating that the pharmacy wanted to review it. When the narcotic book was returned to charge nurse A.F., she realized that the six (6) narcotic sheets she had picked up off the printer had been removed from the book. Charge nurse A.F. spoke to charge nurse D.G. about the incident and they contacted the pharmacy to find out who had withdrawn the medications for their patients. Reports from Alixa showed that Respondent had dispensed those medications. Respondent had removed six (6) prn hydrocodone pills from Alixa using her user name and password. Respondent failed to document the administration or waste of the six (6) prn hydrocodone pills to the patients in the computer system. Respondent additionally failed to submit the narcotic count sheets showing the administration or waste of the six (6) prn hydrocodone pills. When the hydrocodone pills were withdrawn, Respondent was working in her capacity as the Director of Nursing and was not providing direct patient care; she did not inform charge nurses A.F. or D.G. that their patients were experiencing pain; and, she did not inform charge nurses A.F. and D.G. that she had administered pain medications to their patients. When Respondent was questioned by the nursing home administrator regarding the missing six (6) prn hydrocodone pills, Respondent indicated she had given nurse R her password; however, nurse R did not work a shift at the nursing home on July 13, 2015.
Revoked 11/28/2017

James, Deborah K
Springfield, MO
Registered Nurse 101789
The Missouri State Board of Nursing received information from the California Board of Nursing via the NURSYS website that the nursing license of Respondent was revoked in a Default Decision and Order dated May 13, 2016. The Missouri State Board of Nursing received information from the Texas Board of Nursing via the NURSYS website that Respondent's Privilege to Practice nursing in the state of Texas was revoked in a Default Order dated November 8, 2016.
Revoked 09/22/2017

Lines, Julie Michelle
Butler, MO
Licensed Practical Nurse 2007024012
On four (4) separate occasions, September 23, 2016; October 11, 2017; October 19, 2017; and, March 31, 2017, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On March 31, 2017, the Board received a prescription identification form from Dr. J. P., prescribing Respondent 60 tablets of Oxycontin 60mg and 120 tablets of oxycodone 30 mg on March 24, 2017, for pain. On May 26, 2017, the Board received a prescription identification form from Dr. L. P., prescribing Respondent 60 tablets of Oxycontin 60 mg and 120 tablets of oxycodone 30 mg on April 6, 2017, for low back pain. On May 26, 2017, the Board received a prescription identification form from Dr. C. T., prescribing Respondent ten (10) pills of Norco on April 19, 2017, for pain from a root canal. On May 30, 2017, the Board received a prescription identification form from L. M., Pa-C, prescribing Respondent 60 tablets of Oxycontin 60 mg and 120 tablets of oxycodone 30 mg on May 8, 2017, for back pain. On May 30, 2017, the Director of Compliance wrote letters to each of the four (4) individuals who prescribed the Oxycodone, Oxycontin and Norco to inquire whether each had been informed on the previous prescriptions. On June 6, 2017, the Director of Compliance received a letter from Dr. L. P. via facsimile, that he was aware that Dr. J. P. had prescribed oxycodone and Oxycontin, but was unclear of whether she informed him when the medications were prescribed; however, he would have written that she could not fill his prescription until April 23, 2017, if he had been aware that the prescription from Dr. J. P. was issued on March 24, 2017 in the amounts prescribed as that prior prescription should have lasted until April 23, 2017. Dr. L. P. was not made aware of the prescription from Dr. T. for Norco. On June 5, 2017, the Director of Compliance received an e-mail from L. M. Pa-C, that she was not made aware of the prior prescriptions other than the one prescribed by Dr. L. P. on April 6, 2017, when she prescribed 60 tablets of Oxycontin 60 mg and 120 tablets of oxycodone 30 mg on May 8, 2017. She was not informed that Respondent had been prescribed Norco (hydrocodone) by Dr. T. on April 19, 2017. On June 8, 2017, the Director of Compliance received an e-mailed letter from Dr. T. dated June 7, 2017, stating that he was not made aware of the previous amounts or prescriptions that had been previously prescribed, but was aware of an "allegation of chemical dependency." Respondent failed to disclose the previous prescriptions to Dr. L. P., Dr. T. and L. M. before obtaining the new prescriptions on April 6, April 19, and May 8, 2017, within 60 days prior to receiving the prescriptions.
Revoked 09/07/2017

Walzer, Kenya Monique
Grandview, MO
Registered Nurse 2006025384
Respondent failed to check in with NTS on twenty-three (23) days. In addition, on October 28, 2015, Respondent failed to call NTS; however, that was a day that Respondent had been selected to submit a sample for testing. Therefore, Respondent failed to report to a collection site to provide a sample for testing on October 28, 2015. Further, on March 25, 2016, Respondent called NTS and was advised that she had been selected to provide a urine sample for screening. Respondent failed to report to a collection site to provide the requested sample. In addition, on two separate occasions, March 17, 2016, and April 28, 2016, Respondent reported to lab and submitted the required sample which showed a low creatinine reading. On June 23, 2016, Respondent submitted urine and nail samples for random drug screening. That urine sample tested positive for the presence of Lorazepam. The nail sample tested positive for the presence of Oxycodone. Respondent did not have a prescription for, or a lawful reason to possess, Lorazepam or Oxycodone. On February 23, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of marijuana. Respondent does not have a prescription for, or a lawful reason to possess, marijuana. On May 8, 2017, Respondent submitted a urine sample for random drug screening. That sample tested positive for the presence of oxymorphone.
Revoked 09/22/2017

McCarty, Connie Marie
Rockaway Beach, MO
Registered Nurse 2008020781
Respondent failed to check in with NTS on six (6) days. In addition, on five (5) separate occasions, May 26, 2015; February 11, 2016; June 10, 2016; November 21, 2016; and June 12, 2017, Respondent reported to a lab and submitted the required sample which showed a low creatinine reading. On March 28, 2017, Respondent reported to a collection site to provide a sample and the sample tested positive for Ethyl Glucuronide (EtG) and Ethyl Sulfate (EtS), metabolites of alcohol. On June 29, 2017, Respondent reported to a collection site to provide a blood sample, and the sample tested positive for Phosphatidyl Ethanol (PEth), a metabolite of alcohol. Respondent admitted to Dr. Greg Elam that she had been drinking on weekends and would typically have four (4) drinks.
Revoked 09/07/2017

SUSPENDED

Gomez, JaCey Beth
Savannah, MO
Licensed Practical Nurse 2009029700
Suspended 11/21/17-12/05/17; Probated 12/06/17-12/06/19
On December 1, 2016, Licensee was informed by a Certified Nurse's Aide (CNA) that Resident GS refused to shower. Licensee told the CNA to make the resident bathe. In route to the shower resident GS questioned who was making her shower. Licensee raised her voice

Disciplinary Actions**

to resident GS to state that it was her that was making the resident shower. Licensee got into a verbal altercation with resident GS. Further, on December 1, 2016, resident SV spoke with the Administrator of the nursing home regarding Licensee. Resident SV informed the Administrator that Respondent told him that he could not bother the doctors that day or she would take away his electric wheelchair. Additionally, on December 1, 2016, Licensee made resident CM get up and go to breakfast even though resident CM did not want to. Resident CM had informed Licensee that she had been up late and did not want to go to breakfast.
Suspension 11/21/2017 to 12/05/2017

VOLUNTARY SURRENDER

Colvin, Raylene Faye
Kansas City, MO
Registered Nurse 2002028990
Licensee voluntarily surrendered her Missouri nursing license effective November 8, 2017.
Voluntary Surrender 11/08/2017

Smith, Stacia Lee
Nevada, MO
Registered Nurse 2006002040
Licensee was expected to visit patient RH's home on a weekly basis to set up medications. On August 23, 2016, agency administrators received information indicating that Licensee had not visited patient RH's home since June. Licensee had submitted Nurse Visit Reports and timesheets for visits on July 4, 2016; July 11, 2016; July 18, 2016; July 25, 2016; August 1, 2016; August 8, 2016; and August 15, 2016. When questioned by agency administrators, patient RH confirmed that Licensee had not visited the home since June 2016, and stated that the signatures on Licensee's Nurse Visit Reports were not his. On July 11, 2017, Licensee pled guilty to six (6) counts of the class A misdemeanor of Theft/Stealing. Licensee pled guilty to appropriating health care payments.
Voluntary Surrender 10/16/2017

Hogard, Michael E
Lees Summit, MO
Registered Nurse 135356
In February 2016, a hospital nurse case manager received information that Licensee had inappropriate contact with patient B.A. Licensee had offered massages to patient B.A., had texted patient B.A. after she was discharged, and had offered to take patient B.A. to dinner and give her money. Licensee was terminated from the hospital on February 8, 2016 for violating hospital policy by having an inappropriate relationship with a patient. As of August 2017, Licensee is no longer medically fit to practice nursing.
Voluntary Surrender 09/27/2017

Owens, Courtney Diane
Burlington Junction, MO
Registered Nurse 2004011095
Licensee voluntarily surrendered her Missouri nursing license effective November 8, 2017.
Voluntary Surrender 11/08/2017

Mandated Reporters:
New Online Option to Report Child Abuse and Neglect

Report Non-Emergency Child Abuse and Neglect Online

Thanks to your suggestions, we now have a new **ONLINE** option for mandated reporters to report non-emergency child abuse and neglect.

Our new **ONLINE** option:

- ✓ Gives you greater convenience and flexibility to report non-emergency issues
- ✓ Allows you to report no matter where you are
- ✓ Helps you avoid wait time on the Child Abuse and Neglect Hotline

How it works:

- When you're ready to report, go to http://dss.mo.gov/cd/can.htm
- Click on **ONLINE MANDATED REPORTING**
- You will sign up for an account with a few simple steps
- The interactive reporting system prompts you for information about the child, much like a normal hotline call

Once you complete your report:

- The report is immediately uploaded to a secure server
- You will get an email with the assigned call number indicating whether or not your report meets the definition of child abuse or neglect

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Collect all needed information before you start your report.

The report automatically times out after 15 minutes of inactivity.

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- Go to http://dss.mo.gov/cd/can.htm
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- Create an account
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